STATE OF MICHIGAN

RICK SNYDER
GOVERNOR

DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

NICK LYON
DIRECTOR

August 3, 2017

Rick Lowe, Chief Internal Auditor
Office of Internal Audit Services
George W. Romney Building
111 South Capitol, 8th Floor
Lansing, Michigan 48913

Dear Mr. Lowe:

In accordance with the State of Michigan, Financial Management Guide, Part VII, attached are the summary table identifying our responses and corrective action plans to address recommendations contained within the Office of the Auditor General's Performance Audit of the Capitated Rate Setting, Contracting, and Beneficiary Enrollment Processes of the Comprehensive Health Care Program.

Questions regarding the summary table or corrective action plans should be directed to me at 517-373-1508 or MyersP3@michigan.gov.

Sincerely,

Pam Myers, Director
Bureau of Audit, Reimbursement, and Quality Assurance

PM:kk

Enclosure

c: Office of the Auditor General
House Fiscal Agency
Senate Fiscal Agency
Executive Office
DHHS, Nick Lyon
DHHS, Nancy Vreibel
DHHS, Chris Priest
House Appropriations Committee
House Standing Committee
Senate Appropriations Committee
Senate Standing Committee
DHHS, Farah Hanley
DHHS, Geralyn Lasher
DHHS, Karla Ruest

PERFORMANCE AUDIT OF THE CAPITATED RATE SETTING, CONTRACTING, AND BENEFICIARY ENROLLMENT PROCESS OF THE COMPREHENSIVE HEALTH CARE PROGRAM

DEPARTMENT OF HEALTH AND HUMAN SERVICES

JULY 11, 2017

AUDIT RESPONSE

Approved: Farah A. Hanley

Farah A. Hanley, Senior Deputy Director
Department of Health & Human Services

Date: 7/11/17

AUDIT REPORT SUMMARY

DEPARTMENT: Health and Human Services

AUDIT PERIOD: October 1, 2013 through May 31, 2016

REPORT DATED: April 12, 2017

DISPOSITION OF AUDIT RECOMMENDATIONS

CITATIONS COMPLIED WITH	CITATIONS TO BE COMPLIED WITH	CITATIONS DCH DID NOT AGREE WITH
	Finding 1 (12/31/17)	

Audit Response
Performance Audit
Capitated Rate Setting, Contracting, and
Beneficiary Enrollment Process of the
Comprehensive Health Care Program
Department of Health & Human Services
October 1, 2013 through May 31, 2016

Recommendation 1: Improvements needed for data accuracy.

The OAG recommend that MDHHS improve its processes to help ensure the accuracy of the data used for developing the capitated rates.

Response:

MDHHS acknowledges there are opportunities for incremental improvement in the procedures for ensuring the accuracy of the data used by its actuary for capitated rate setting:

a. During the audit period MDHHS relied on the processes it had in place which included the overpayment reporting historically done by the managed care organizations utilizing a claim replacement process. In their reporting to the Office of the Auditor General (OAG), the health plans explained how overpayments are reported to MDHHS through a reversal and adjustment process. Overpayments are treated the same as other claims adjustments and resubmitted through the encounter file using a frequency code of 7 (replacement). When the data is pulled for rate setting purposes, only the replacement file is sent to the actuary for use. Therefore, overpayments are excluded from the rate setting process. However, MDHHS has worked with its actuary to implement additional reporting mechanisms for overpayments.

   As indicated by the health plans, pharmacy rebates and reinsurance reimbursement are reported to the Michigan Department of Insurance and Financial Services (DIFS) and these reports are used by the actuary as part of a reasonableness check during rate setting. Also, beginning with FY17 rate setting, MDHHS and Milliman surveyed the health plans regarding a variety of financial information, including pharmacy rebates, and third party liability. This information was used in the rate setting process in FY17. MDHHS and Milliman are in the process of surveying the health plans for FY18 rate setting.

   The adjustments made by the actuary were consistent with the information provided by the health plans to the OAG. The amounts reported were 0.2% and 0.3% and Milliman used 0.5% in rate setting. Milliman did not apply a TPL adjustment to the HMP rates since historical information related to third-party recoveries was not available for this new program. TPL data is part of the information requested by the survey tool MDHHS and Milliman implemented for FY17 rate setting.

b. MDHHS agrees that any technical assistance related to the Encounter Quality Initiative (EQI) process could be provided on a more routine basis. However, the EQI process is used throughout the year with four-month data set pulls and is a totally different data pull than the final data used for the rate setting process. The EQI is designed to help health plans understand where improvements can be made in their encounter data submission process. During the audit period, MDHHS used the EQI process to provide technical assistance to health plans during onsite visits.

MDHHS is working to strengthen the effectiveness of the EQI process. Changes currently underway include dispersing the responsibility of working with health plans to several individuals in the section instead of relying on a single individual. An Encounter Quality Liaison has been assigned to each health plan. These liaisons will meet monthly with their assigned health plans to discuss EQI results, volume, and timeliness reports as well as any other data quality issues.

c. MDHHS agrees and will develop a process to work with the health plans whose data was excluded from the rate setting process by the actuary to implement improvements in their encounter data submissions. This will be addressed by the Encounter Quality Liaisons as they work with their assigned health plan.

d. MDHHS believes the multiple methods it uses to track program changes for inclusion in the rate setting process serve as a formal tracking process. These methods include the following: 1) Bi-weekly meetings coordinated by the Actuarial Division to work with the Managed Care Division and other appropriate MSA staff to identify and track program changes which impact rate development. These meetings are documented with notes and agendas which identify program changes. 2) Bi-weekly meetings with the actuary and the Actuarial Division management to discuss program changes and other rate setting issues. 3) Bi-weekly Operations meetings with the health plans where upcoming program changes are discussed and documented. 4) Bi-Monthly meetings with the health plans where program changes are discussed and documented. 5) Pre-rate setting meetings where the actuary presents the rate setting methodology and program changes to the health plans prior to rate setting. 6) Bi-monthly meetings with health plan CEOs where significant program changes are discussed and documented. 7) Annual rate setting meeting with the health plans after the rates have been set where program changes are described and documented. However, MDHHS acknowledges that these documents were not provided during the audit process.

e. MDHHS has developed a formal approval process for contract deliverables.